

**BOARD OF REGISTERED NURSING  
Nursing Practice Committee  
Agenda Item Summary**

---

**AGENDA ITEM:** 11.1

**DATE:** April 18, 2008

**ACTION REQUESTED:** Approve/Not Approve: Nursing Practice Committee  
Goals and Objectives 2008-2009

**REQUESTED BY:** Susanne Phillips, MSN, RN, NP, Chair  
Nursing Practice Committee

**BACKGROUND:**

**NEXT STEP:** Place on Board Agenda

**FISCAL IMPLICATIONS,  
IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN  
Nursing Education Consultant  
(916) 574-7686

**BOARD OF REGISTERED NURSING  
NURSING PRACTICE COMMITTEE**

**2008/2009 Goals and Objectives**

---

**Goal 1.**

**In support of the consumer's right to quality care, identify and evaluate issues related to registered nursing tasks being performed by unlicensed assistive personnel.**

- 1.1 *Take an active role in activities conducted by other agencies and organizations related to unlicensed assistive personnel.*
  - 1.2 *Disseminate orally and in writing, the Board's position on the use of unlicensed assistive personnel and/or regulations once accepted.*
- 

**Goal 2.**

**Promote patient safety as an essential and vital component of quality nursing care.**

- 2.1 *Engage and dialogue with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example just culture and root cause analysis, failure mode and effect analysis, human factor and systems factor.*
  - 2.2 *Monitor patient safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortage, ethics, lifelong learning, nursing standards, licensure, safety legislation, magnet hospitals.*
- 

**Goal 3.**

**Develop and implement processes for the Board to interact with stakeholders to identify current trends and issues in nursing practice and the health care delivery system.**

- 3.1 *Actively participate with other public and private organizations and agencies involved with health care to identify common issues and to promote RN scope of practice consistent with the Nursing Practice Act and ensuring consumer safety.*
- 3.2 *As nursing practice issues arise, convene BRN focus groups of RNs for input in shaping Board policy.*

- 3.3 *Research, monitor, and evaluate the newly developing nursing practice arena of telenursing and disease state management, including the relationship with telehealth and telemedicine and to coordinate with public and private agencies dealing with these issues.*
  - 3.4 *Promote technology awareness and technology innovations in the healthcare delivery systems such as computerization medical and nursing data as relates to nursing care delivery and quality patient care.*
- 

#### **Goal 4.**

##### **Identify and implement strategies to impact identified trends and issues.**

- 4.1 *Provide timely written and/or verbal input on proposed regulations related to health care policies affecting nursing care.*
  - 4.2 *Collaborate with the Education/Licensing Committee on educational issues/trends and the Legislative Committee on legislation pertaining to nursing practice.*
  - 4.3 *Review and revise current BRN advisory statements and recommend new advisory statements as needed to clarify standards of nursing practice.*
- 

#### **Goal 5.**

##### **Develop and implement processes for the Board to interact with stakeholders to identify and evaluate issues related to advanced practice nursing and to promote maximum utilization of advanced practice nursing.**

- 5.1 *Support and promote full utilization of advanced practice nurses.*
- 5.2 *Monitor trends and growing opportunities for advanced practice nursing in areas of health promotion, prevention and managing patients through the continuum of care.*
- 5.3 *Actively participate with organizations and agencies focusing on advanced practice nursing.*
- 5.4 *In collaboration with the Education/Licensing Committee remain actively involved in facilitating communication and work in progress for education/certification function and communication with advanced practice educational program directors, professional organizations, state agencies and other groups.*

**BOARD OF REGISTERED NURSING  
Nursing Practice Committee  
Agenda Item Summary**

---

**AGENDA ITEM:** 11.2

**DATE:** April 18, 2008

**ACTION REQUESTED:**

Information Only:

(a) California HealthCare Foundation, January 2008:  
Scope of Practice Laws in Health Care: Rethinking the  
Role of Nurse Practitioners

(b) The Center for the Health Professions, UCSF,  
2007, Overview of Nurse Practitioner Scopes in the  
United States-Discussion

**REQUESTED BY:**

Susanne Phillips, MSN, RN, NP, Chair  
Nursing Practice Committee

**BACKGROUND:**

**(a) Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners.**

Key Findings of the Survey:

- NPs are registered nurses with advanced clinical training. They serve as primary care providers in a broad range of acute and outpatient settings, such as pediatrics, internal medicine, anesthetics, geriatrics, and obstetrics
- NPs began to practice in the 1960's, in response to a nationwide physician shortage. Today, there are an estimated 145,000 NPs nationwide, and 13,649 in California.
- The 50 states and the District of Columbia have individual control over the laws that govern NP scope of practice. This has resulted in wide state-by-state differences in the types of services that NPs can deliver to their patients.
- These differences in scope of practice may slow the uniform expansion of NP services, prohibit NPs from providing the care for which they are trained, and hampered the use of NPs in improving access and controlling health care costs.
- California is roughly in the middle, nationwide, in NP practice autonomy and independence. NPs must collaborate with physicians and develop joint, written protocols that cover all major elements of the NP practice.
- California NPs may diagnose, order tests and durable medical equipment, refer patients, and "furnish" or "order" drugs, but only according to that protocol. There is a cap of four drug prescribing NPs per physician.
- Six states---Alaska, Arizona, New Hampshire, New Mexico, Oregon, and Washington---have NP scopes of practice that are among the nations most expansive. In these states, NPs practice autonomously, with not physician oversight, and prescribe drugs without physician involvement.

The conclusion of this report:

Today there is a great deal of discussion in health policy circles, in California and across the country, of an impending physician shortage. In many ways, this current debate mirrors the events of the 1960's which spawned the initial development of the nurse practitioner.

Despite wide state-by-state differences in practice authorities, NPs deliver comprehensive medical services in a variety of settings and specialties, which are largely comparable to those provided by physicians, both in scope and medical outcomes.

The reappearance of the physician shortage issue suggests that the efficiency, accessibility, and quality of the health care system could benefit from the increased inter-professional collaboration, and be revised models for delivery of medical services that employ uniform, shared scopes of practice among providers

And with California possibly poised to overhaul its system of health care coverage, a review of the nurse practitioner's role in that system may become a part of the plan.

California Health Care Foundation, January 2008

**(b) The Center for the Health Professions, UCSF. Overview of NP Scopes of Practice in the US - Discussion. Executive Summary**

Nurse Practitioners (NPs) are registered nurses who are prepared beyond initial nursing education in a NP program to provide primary care directly to patients. The profession originated in the mid-1960s in response to shortage of physicians (MDs). NP education requirements, certification mechanisms and legal scopes of practice are decided at the state level and vary considerably.

NP scopes of practice vary widely among the states:

- Eleven states permit NPs to practice independently, without physician involvement
- Twenty-seven permit NPs to practice in collaboration with an MD. Collaboration definitions vary, but written practice protocols are often required
- Ten states require MD supervision of NPs
- NPs in all states may prescribe, but MD involvement is generally required to varying degrees. Additional limitations such as 72-hour or 30-day supplies may apply.
- Specific practice authorities are sometimes articulated although states may require MD involvement for any task: 44 states explicitly authorize NPs to diagnose (sometimes limited to a nursing diagnosis): 33 states explicitly authorize NPs to refer; and 20 states explicitly authorize NPs to order tests.

Education and certification requirements vary:

- Forty-two states require national certification as part of NP licensure.

- Just over half of the states require NPs to be prepared with a master's degree, while some states only require completion of a few months of post-RN education

Implications of current policy:

- Preventing professionals from practicing to the full extent of their competence negatively affects health care costs, access and quality.
- NP practices are impeded by scope of practice laws, financing and reimbursement mechanisms, malpractice insurance policies and outdated practice models.
- The professions and the public are ill-served when practice authorities differ dramatically among states.

Policy options to consider:

- Continue trend to expand NP scope of practice to match competence.
- Adopt uniform scope of practice laws to reduce variability among states
- Increase number of NP programs to reflect growing demand for primary care

UCSF Center for the Health Professions, 2007: Sharon Christian, JD, Catherine Dower, JD and Ed O'Neil, PhD, MPA, FAAN.

**NEXT STEP:** Place on Board Agenda

**FISCAL IMPLICATIONS, IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN  
Nursing Education Consultant  
(916) 574-7686

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

---

**AGENDA ITEM:** 11.3

**DATE:** April 18, 2008

**ACTION REQUESTED:** Information Only: Center for American Nurses Calls For an End to Lateral Violence and Bullying in Nursing Work Environments – New position statement offers information and recommended strategies

**REQUESTED BY:** Susanne Phillips, MSN, RN, NP, Chair  
Nursing Practice Committee

**BACKGROUND: Statement of Position**

Lateral violence and bullying has been extensively reported and documented among healthcare professionals with serious, negative outcomes for registered nurses, their patients, and health care employers. These disruptive behaviors are toxic to the nursing profession and have a negative impact on retention of quality staff. Horizontal violence and bullying should never be considered normally related to socialization in nursing nor accepted professional relationships. It is the position of the CENTER for American Nurses (The CENTER) that there is no place in a professional practice environment for lateral violence and bullying among nurses or between healthcare professionals. All healthcare organizations should implement a zero tolerance policy related to disruptive behavior, including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior. (Approved February 2008)

The CENTER in its statement defines bullying and lateral violence, disruptive behavior, culture of safety, workplace bullying and verbal abuse.

The CENTER adopted position statement which includes recommended strategies that nurses, employers/organizations, continuing education and academic programs and nursing researchers can employ to eliminate lateral violence and bullying.

The Center for American Nurses is a national professional nursing organization that educates, equips, and empowers nurses to advocate for themselves, their profession, and their patients. The Center offers evidence-based solutions and powerful tools to navigate workplace challenges, optimize patient outcomes, and maximize career benefits. Established in 2003, The Center partners with its 42 organization members, comprised of over 47,000 registered nurses nationwide, to develop resources, strategies, and tools to help nurses manage evolving workforce issues and succeed in their careers. Additional information about the Center can be found at [www.centerforamericannurses.org](http://www.centerforamericannurses.org).

**NEXT STEP:** Place on Board Agenda

**FISCAL IMPLICATIONS, IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN, NEC  
(916) 574-7686

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

---

**AGENDA ITEM:** 11.4

**DATE:** April 18, 2008

**ACTION REQUESTED:** Information Only: CMS February 8, 2008: Hospital-Revised Interpretive Guidelines for Hospitals Condition of Participation (Medicare)

**REQUESTED BY:** Susanne Phillips, MSN, RN, NP, Chair  
Nursing Practice Committee

**BACKGROUND:**

The attached are the interpretive guidelines correspond with the regulatory changes published November 27, 2006 amending Hospitals Conditions of Participation pertaining to requirements for history and physicals examination; authentication of verbal orders; securing medications; and post anesthesia evaluation.

The interpretive guidelines are import for registered nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified nurse anesthetists.

The following is a brief report and full text can be reviewed in the attachment to this agenda item.

**History and Physical:** § 482.22 (c) (5) (i)

**Physician:** Requirement for medical history and physical examination and purpose of the H&P. Medical Staff bylaws must address requirement for H&P 30 days prior to or 24 hours after hospital admission but prior to surgery or a procedure that requires anesthesia

Other qualified licensed individuals are those practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform an H&P and who are formally authorized by the to conduct an H&P. Other qualified licensed practitioners could include nurse practitioners and physician assistants.

**Nursing Services:** § 482.54 (b) (1)

The hospital must provide nursing services 24 hours a day, 7 days a week. LPN can provide nursing services if a RN, who is immediately available for the bedside care of those patients, supervises care.

**Exception:** § 488.54 (c) sets forth certain conditions under which rural hospitals of 50 beds or fewer may be granted a temporary waiver of the 24 hour registered nurse requirement by the regional office.

**Influenza and pneumococcal polysaccharide vaccines:** § 482.23 (c) (2)

With the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accord with State law, and who is responsible for the care of the patient as specified under § 482.12 (c)



Nurse Practitioners and Physician Assistants responsible for the care of specific patients are also permitted to order drugs and biologicals in accord with delegation agreements, collaborative practice agreements, hospital policy and State law.

**Note:** If a hospital uses other written protocols or standing orders for drugs or biologicals that have been reviewed and approved by the medical staff, initiation of such protocol or standing orders requires an order from the practitioner responsible for patient care.

*Hospitals are encourage to promote a culture in which it is not only acceptable, but also strongly encouraged, for staff to bring to the attention of the prescribing practitioner questions or concerns they have regarding orders. Any questions about the order for drugs or biologicals are expected to b e resolved prior to the preparation, or dispensing, or administration of the medication.*

**Verbal Orders:** § 482.23 (c) (2) (i)

Verbal orders, if used, must be used infrequently. This means that the use of verbal orders must not be a common practice. Verbal orders pose an increased risk of miscommunication that could contribute to a medication or other error, resulting in a patient adverse event. Verbal orders should be used only to meet care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter the order into a computer (in case of a hospital with an electronic prescribing system) without delay of treatment. Verbal orders are not to be used for the convenience of the ordering practitioner.

Hospitals are expected to develop appropriate policies and procedures that govern the use of verbal orders and minimize their use. **CMS expects nationally accepted read-back verification practice to be implemented for every verbal order.** (71 FR 68680)

Verbal orders must be clearly communicated. All verbal orders must be immediately documented in the patient's medical record and signed by the individual receiving the order. Verbal orders should be recorded directly onto an order sheet in the patient's medical record or entered into the computerized order entry system.

**Accepting Verbal Orders:** § 482.23(c) (2) (ii)

When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedure consistent with Federal and State laws.

**Patient medical record entries:** § 482.24 (c) (1)

All patient medical record entries must be legible, complete, dated, times and authenticated in written or electronic form by person responsible for providing or evaluating the services provided, consistent with hospital policies and procedures.

**Authenticated verbal orders:** § 482.9 (c) (1) (iii)

All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.

**Drugs and biologicals:** § 482.25 (b) (2) (i)

All drugs and biologicals must be kept in a secure area, and locked when appropriate.

(71FR 68689) This regulation gives hospitals the flexibility to integrate patient self-administration of non-controlled drugs and biologicals into their practices as appropriate.

**Pre-anesthesia evaluation:** § 482.51(b) (1)

The pre-anesthesia evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. At a minimum, the pre-operative anesthetic evaluation of the patient should include:

- Notation of anesthetic risk:
- Anesthetic drug and allergy history:
- Any potential anesthesia problems identified
- Patient's condition prior to induction of anesthesia

**Post-anesthesia evaluation:** § 482.52 (b) (3)

A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. In accordance with § 482.52

(a) anesthesia must be administered only by:

- A qualified anesthesiologist
- A doctor of medicine or osteopathy (other than an anesthesiologist)
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law
- A certified registered nurse anesthetist (CRNA), who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or
- An anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed.

**NEXT STEP:** Place on Board Agenda

**FISCAL IMPLICATIONS, IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN  
Nursing Education Consultant  
(916) 574-7686

**BOARD OF REGISTERED NURSING  
Nursing Practice Committee  
Agenda Item Summary**

---

**AGENDA ITEM:** 11.5

**DATE:** April 18, 2008

**ACTION REQUESTED:** Information Only: Reorganization of Nurse Practitioner  
Information on BRN website

**REQUESTED BY:** Susanne Phillips, MSN, RN, NP, Chair  
Nursing Practice Committee

**BACKGROUND:**

**NEXT STEP:** Place on Board Agenda

**FISCAL IMPLICATIONS, IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN  
Nursing Practice Committee  
(916) 574-7686

## Laws and Regulations: Nurse Practitioner

### The law:

#### Article 8 Nurse Practitioner §2834-2837

- 2834 Legislative findings
- 2835 License requirements
- 2835.5 Submission of credentials
- 2836 Establishment of categories and standards
- 2836.1 Furnishing or ordering of drugs and devices by NPs
- 2836.2 What Constitutes furnishing or ordering of drugs or devices
- 2836.3 Issuance of number to nurse practitioner dispensing drugs or devices
- 2837 Registered nursing practice not limited

### The Regulation

#### Article 8 Standards for Nurse Practitioners §1480-1485

- 1480 Definitions
- 1481 Categories of Nurse Practitioners
- 1482 Requirements for Holding Out as a Nurse Practitioner
- 1483 Evaluation of Credentials
- 1484 Standards of Education
- 1485 Scope of Practice

## Laws and Regulations for RNs including identifying sections applicable to the Nurse Practitioner practice

#### Article 2 Scope of Regulation §2725-2742

- 2725 Legislative intent; Practice of nursing defined
- (NP function by Standardized Procedures § 2725 ©)
- 2725.1 Dispensing of drugs or devices by RNs (NPs)
- 2725.3 Functions performed by unlicensed personnel
- 2725.5 "Advanced practice registered nurse" defined
- 2726 Unauthorized practices
- 2727 Practices not prohibited
- 2727.5 Liability for emergency care
- 2728 Services by attendants and psychiatric technicians

- 2728.5 Utilization of licensed psychiatric technicians and psychiatric technician interim permittees
- 2729 Services by a student nurse
- 2730 Nurse qualified outside state and engaged to care for patient temporarily in California
- 2731 Nonprofit religious care
- 2732 Licensure requirement: Use of "R.N."
- 2732.05 Verification of current R.N. status
- 2732.1 Applications; Interim permits
- 2733 Issuance of a temporary license where examination is waived
- 2734 Inactive Licenses
- 2736 Qualifications generally
- 2736.1 Training in detection and treatment of client abuse, and alcohol and chemical substance dependency
- 2736.5 Qualifications of persons serving in medical corps of armed services; Records and Reports
- 2736.6 Eligibility of vocational nurse to take examination for licensure as registered nurse